Arizona Health Care Cost Containment System

July-August, 2002

ENCOUNTER KEYS

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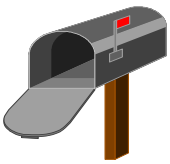

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TOO MANY REPORTS?

Based on Contractor and AHCCCS staff feedback, there appears to be interest in redesigning or eliminating some encounter reports. Please review your reports and be prepared to discuss your desired changes at the next Quarterly Meeting.

QUARTERLY MEETING

The next quarterly Contractor Encounter Meeting will be held on July 31st, 2002; in the Gold Room, 701 East Jefferson; from 2:00 p.m. to 4 p.m.

CODES AVAILABLE ONLY FOR BEHAVIORAL HEALTH SERVICES

Procedure codes 99371-99373 (Telephone Call by a Physician to Patient or for Consultation) are **available for encounter reporting only by ADHS/ Behavioral Health Services**. These codes cannot be reported by other health plans and program contractors. If the codes are used, they will pend for error code S600 (Procedure Code Available Only for Behavioral Health Services).

INPATIENT HOSPITAL ENCOUNTER REPORTING TIPS

Inpatient same-day admit/discharge encounters reported with paid accommodation revenue codes will pend with edit V673-Discharge Day Accommodation Not Covered, Non-Cover Accommodation Day Line. To clear the edit, enter the billed charge in the non-covered charges field.

Inpatient hospital encounters should be reported with all billed ancillary revenue codes. If an ancillary revenue code is fully or partially denied, enter the denied charges in the non-covered charges field. If no ancillary charges are reported the encounter will pend with edit V060 - Ancillary Revenue Codes Required.

DILEMMAS

For the months of July and August the following error code conditions are not subject to sanction.

S385 – Service Units Exceed Maximum Allowed (pertains only to the 80000 procedure codes).

P015 - Service Provider Type Invalid For Uniform Billing Form

R295– Medicare Reported But Not Indicated (Only for Part B on facility encounters**)**

S841 - ASC Procedure Code Is Not Covered

S842 - ASC Procedure Code is Not Classified

Attending Provider ID

Attending Provider ID has been changed from (R) required to (A) required if applicable for inpatient encounters.

ELECTRONIC THIRD PARTY LIABILITY UPDATES

AHCCCS has developed a process to electronically update Third Party Liability (TPL) data from Contractors. Contractors will be able to provide AHCCCS with electronic updates, which will replace the current paper process. Please note that the electronic TPL update process currently excludes Medicare.

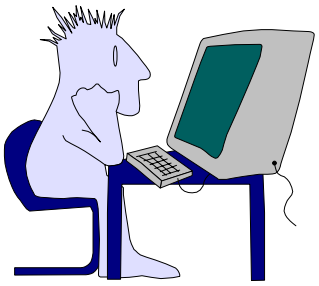
All Contractors must successfully test the electronic TPL update process prior to implementing it for production updates.

Contractors were recently sent additional information, including technical specifications via e-mail.

COVERAGE CODE DESCRIPTIONS CHANGED

The AHCCCS coverage codes found in the PMMIS system Reference screen RF102 have been changed for clarity.

01 Covered Service/Code Available	Service is covered, code is accepted by both Administration fee-for-service claims and contractor encounters
02 Not Covered Service/Code Available	Service is not covered by Administration fee-for-service claims, but code is accepted for contractor encounters
03 Covered Service/Use Other Code	Service is covered but must be reported using a different code. Please verify with provider.
04 Not Covered Service/Code Not Available	Service is not covered, code is not accepted for Administration fee-for-service claims or contractors encounters
08 Covered Service/Code Replaced	Service is covered but code has been replaced by another code



SYSTEM UPDATES

Surgery Added to Office Setting

Effective on or after January 1, 2000, surgical procedure for reduction of over correction of ptosis (67909) is allowed in an office setting (place of service 11).

Monitoring Codes Allowed for Laboratories

Effective on or after July 1, 2001, laboratories (Provider Type 4) may report the following codes:

G0004 Patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30-day period; includes transmission, physician review and interpretation
G0005 Patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30-day period; recording (includes hook-up, recording, and disconnection)
G0006 Patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30-day period; 24-hour attended monitoring, receipt of transmissions, and analysis
G0007 Patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30-day period; physician review and interpretation only and
G0015 Post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24-hour attended monitoring, per 30-day period; tracing only

Radiology Category of Service Added to Provider Types 18, Physician Assistants, and 19, Nurse Practitioners

Effective with dates of service on and after January 01, 2001 the following CPT codes have been approved for use by Physicians Assistant (Provider Type 18) and Registered Nurse Practitioners (Provider Type 19):

71010 Radiologic examination, chest; single view, frontal
71020 Radiologic examination, chest, two views, frontal and lateral
73060 Radiologic examination; humerus, minimum of two views
73090 Radiologic examination; forearm, two views
73092 Radiologic examination; upper extremity, infant, minimum of two views
73550 Radiologic examination, femur, two views
73590 Radiologic examination; tibia and fibula, two views
73592 Radiologic examination; lower extremity, infant, minimum of two views

Self Administrable Drugs Revenue Code Allowed for Critical Access Hospital

Effective with Dates of Services on or after October 1, 2001, revenue code 637 (Self-Administrable Drugs) can be reported on the Uniform Billing form (UB-92) with the following bill types:

851 Critical Access Hospital; Admit thru Discharge
852 Critical Access Hospital; Interim, 1st Claim
853 Critical Access Hospital; Interim, Continued Claim
854 Critical Access Hospital; Interim, Last Claim
855 Critical Access Hospital; Late Charges Only Claim
856 Critical Access Hospital; Adjustment, Prior Claim
857 Critical Access Hospital; Replacement, Prior Claim
858 Critical Access Hospital; Void/Cancel Prior Claim

UPDATES CONTINUED

New Age Limits Set for Repair, Revision, and/or Reconstruction Surgery Codes

The age limit has been lowered to 6 months on the following codes:

21120 Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121 Genioplasty; augmentation (autograft, allograft, prosthetic material) sliding osteotomy, single piece
21122 Genioplasty; augmentation (autograft, allograft, prosthetic material) sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123 Genioplasty; augmentation (autograft, allograft, prosthetic material) sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125 Augmentation, mandibular body or angle; prosthetic material
21127 Augmentation, mandibular body or angle; prosthetic material with bone graft, onlay or interpositional (includes obtaining autograft)
21137 Reduction forehead; contouring only
21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139 Reduction forehead; contouring and setback of anterior frontal sinus wall
21141 Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142 Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft
21143 Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft
21145 Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (including obtaining autografts)
21146 Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147 Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150 Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
21151 Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining auto grafts); without LeFort I
21155 Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining auto grafts); with LeFort I
21159 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160 Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172 Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180 Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)

21181 Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
21182 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 cm²
21183 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 cm² but less than 80 cm²
21184 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 cm²
21188 Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining auto grafts)
21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtain ing graft)
21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196 Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198 Osteotomy, mandible, segmental

Other Changes

◊ The age limit has been lowered to 0 for diagnosis code 623.8 – Other specified noninflammatory disorders of vagina

◊ The age limit has been lowered to 3 for procedure code E0784 –External Ambulatory Infusion Pump, Insulin

◊ The age limit has been removed from 33530-Reoperation, coronary artery bypass procedure or valve

◊ 57284 -Paravaginal Defect Repair (Including Repair of Cystocele) has been added to Place of Service 22

The following procedure codes have been added to Provider Type 69 (Optometrist), with an effective date of January 1, 2001:

65275 – Repair of laceration; conjunctiva, cornea, nonperforating, with or without removal foreign body
65430 – Scraping of cornea, diagnostic, for smear and/or culture
65435 – Removal of corneal epithelium; with or without chemocauterization
66999 – Unlisted procedure anterior segment of eye
67938 – Removal of embedded foreign body, eyelid
68020 – Incision of conjnctiva, drainage of cyst
68810 – Probing of nasolacrimal duct, with or without irrigation
68840 – Probing of lacrimal canaliculi, with or without irrigation
95930 – Visual evoked potential (VEP) testing central nervous system
99271 – 99275 Confirmatory Consultation For A New or Established Patient
99311 – 99313 Subsequent Nursing Facility Care, Per Day
99321 – 99323-Domiciliary Or Rest Home Visit For The Evaluation & Management
99331 – -9333-Domiciliary Or Rest Home Visit For The Evaluation & Management
99341 – 99350-Home Visit For The Evaluation & Management of a New Patient
99499 – Unlisted Evaluation & Management